		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045666

Facility Name: CAPITOL CARE CENTER

Address: 555 WEST CARPENTER (Number) SPRINGFIELD (City) 62702 (Zip Code)

County: SANGAMON

Telephone Number: (217) 525-1880 **Fax #** (217) 525-7762

IDPA ID Number: 371414170001

Date of Initial License for Current Owners: 10/01/01

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DARRYL BUEKER **Telephone Number:** (417) 865-8701

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) DARRYL BUEKER, CPA
(Firm Name & Address) BKD, LLP
P. O. Box 1190, Springfield, MO 65801-1190
(Telephone) (417) 865-8701 Fax # 417 865-0682

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	251	Skilled (SNF)	251	91,615	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	251	TOTALS	251	91,615	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	59,090	1,747	13,425	74,262	8
9	SNF/PED					9
10	ICF		8,741		8,741	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	59,090	10,488	13,425	83,003	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.60%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/01

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/01 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 251 and days of care provided 13,425

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	312,736	38,828	27,238	378,802		378,802		378,802			1
2	Food Purchase		328,595		328,595		328,595	(206)	328,389			2
3	Housekeeping	170,278	35,253		205,531		205,531	564	206,095			3
4	Laundry	172,338	34,119		206,457		206,457		206,457			4
5	Heat and Other Utilities			215,604	215,604		215,604	941	216,545			5
6	Maintenance	143,373		113,333	256,706		256,706	822	257,528			6
7	Other (specify):*											7
8	**TOTAL General Services**	798,725	436,795	356,175	1,591,695		1,591,695	2,121	1,593,816			8
	B. Health Care and Programs											
9	Medical Director			25,931	25,931		25,931		25,931			9
10	Nursing and Medical Records	2,888,301	166,631	83,608	3,138,540		3,138,540		3,138,540			10
10a	Therapy	8,790		797,418	806,208		806,208		806,208			10a
11	Activities	98,677	8,130	343	107,150		107,150		107,150			11
12	Social Services	59,830		3,164	62,994		62,994		62,994			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,055,598	174,761	910,464	4,140,823		4,140,823		4,140,823			16
	C. General Administration											
17	Administrative	82,592		688,177	770,769		770,769	(310,961)	459,808			17
18	Directors Fees											18
19	Professional Services			117,510	117,510		117,510	23,643	141,153			19
20	Dues, Fees, Subscriptions & Promotions			75,280	75,280		75,280	(55,697)	19,583			20
21	Clerical & General Office Expenses	509,904	46,671	83,058	639,633		639,633	94,375	734,008			21
22	Employee Benefits & Payroll Taxes			655,970	655,970		655,970	(9,531)	646,439			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,884	7,884		7,884	331	8,215			24
25	Other Admin. Staff Transportation			48,083	48,083		48,083	1,938	50,021			25
26	Insurance-Prop.Liab.Malpractice			165,590	165,590		165,590	2,714	168,304			26
27	Other (specify):*							14,453	14,453			27
28	**TOTAL General Administration**	592,496	46,671	1,841,552	2,480,719		2,480,719	(238,735)	2,241,984			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,446,819	658,227	3,108,191	8,213,237		8,213,237	(236,614)	7,976,623			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CAPITOL CARE CENTER #0045666 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			55,652	55,652		55,652	(28,481)	27,171			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,534	53,534		53,534	(2,018)	51,516			32
33	Real Estate Taxes			36,426	36,426		36,426	3,408	39,834			33
34	Rent-Facility & Grounds			797,051	797,051		797,051	11,991	809,042			34
35	Rent-Equipment & Vehicles			141,203	141,203		141,203	2,008	143,211			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,083,866	1,083,866		1,083,866	(13,092)	1,070,774			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		368,251		368,251		368,251		368,251			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			137,424	137,424		137,424		137,424			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		368,251	137,424	505,675		505,675		505,675			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,446,819	1,026,478	4,329,481	9,802,778		9,802,778	(249,706)	9,553,072			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(29,617)	30		9
10	Interest and Other Investment Income	(2,018)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(206)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,295)	21		18
19	Entertainment				19
20	Contributions	(2,500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(54,555)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(28,667)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (125,858)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(123,848)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (123,848)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (249,706)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

CAPITOL CARE CENTER

ID# 0045666

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank fees	$ (4,090)	21	1
2	Taxes - General	(704)	21	2
3	Entertainment Expense	(9,531)	22	3
4	Real Estate accrual adjustment	3,408	33	4
5	Lobbying Expense	(2,975)	20	5
6	Management Fees	(14,775)	17	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(28,667)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(206)	0	0	0	0	0	0	0	0	0	0	(206)	2
3	Housekeeping	0	0	564	0	0	0	0	0	0	0	0	564	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	941	0	0	0	0	0	0	0	0	941	5
6	Maintenance	0	0	822	0	0	0	0	0	0	0	0	822	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(206)	0	2,327	0	0	0	0	0	0	0	0	2,121	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(14,775)	0	(296,186)	0	0	0	0	0	0	0	0	(310,961)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	23,643	0	0	0	0	0	0	0	0	23,643	19
20	Fees, Subscriptions & Promotions	(57,530)	0	1,833	0	0	0	0	0	0	0	0	(55,697)	20
21	Clerical & General Office Expenses	(15,589)	0	109,964	0	0	0	0	0	0	0	0	94,375	21
22	Employee Benefits & Payroll Taxes	(9,531)	0	0	0	0	0	0	0	0	0	0	(9,531)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	331	0	0	0	0	0	0	0	0	331	24
25	Other Admin. Staff Transportation	0	0	1,938	0	0	0	0	0	0	0	0	1,938	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,714	0	0	0	0	0	0	0	0	2,714	26
27	Other (specify):*	0	0	14,453	0	0	0	0	0	0	0	0	14,453	27
28	**TOTAL General Administration**	(97,425)	0	(141,310)	0	0	0	0	0	0	0	0	(238,735)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(97,631)	0	(138,983)	0	0	0	0	0	0	0	0	(236,614)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(29,617)	0	1,136	0	0	0	0	0	0	0	0	(28,481)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,018)	0	0	0	0	0	0	0	0	0	0	(2,018)	32
33	Real Estate Taxes	3,408	0	0	0	0	0	0	0	0	0	0	3,408	33
34	Rent-Facility & Grounds	0	0	11,991	0	0	0	0	0	0	0	0	11,991	34
35	Rent-Equipment & Vehicles	0	0	2,008	0	0	0	0	0	0	0	0	2,008	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(28,227)	0	15,135	0	0	0	0	0	0	0	0	(13,092)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(125,858)	0	(123,848)	0	0	0	0	0	0	0	0	(249,706)	45

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	Home Office Expense	$ 48,157	Wood Glen Pavilion		$ 48,157	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 48,157			$ 48,157	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Home Office Expense	$ 315,000	Platinum Health Care, LLC	100.00%	$	$ (315,000)	15
16	V	3	Housekeeping		Platinum Health Care, LLC	100.00%	564	564	16
17	V	5	Utilities		Platinum Health Care, LLC	100.00%	941	941	17
18	V	6	Repairs & Maintenance		Platinum Health Care, LLC	100.00%	822	822	18
19	V	19	Professional Fees		Platinum Health Care, LLC	100.00%	23,643	23,643	19
20	V	20	Fees, Subscriptions		Platinum Health Care, LLC	100.00%	1,833	1,833	20
21	V	21	Office Expenses		Platinum Health Care, LLC	100.00%	25,621	25,621	21
22	V	21	Clerical Salaries		Platinum Health Care, LLC	100.00%	84,343	84,343	22
23	V	24	Education & Seminars		Platinum Health Care, LLC	100.00%	331	331	23
24	V	25	Travel		Platinum Health Care, LLC	100.00%	1,938	1,938	24
25	V	27	Employee Benefits		Platinum Health Care, LLC	100.00%	14,453	14,453	25
26	V	26	Insurance		Platinum Health Care, LLC	100.00%	2,714	2,714	26
27	V	30	Depreciation		Platinum Health Care, LLC	100.00%	1,136	1,136	27
28	V	34	Office Rent		Platinum Health Care, LLC	100.00%	11,991	11,991	28
29	V	17	Administrative Salary		Platinum Health Care, LLC	100.00%	18,814	18,814	29
30	V	35	Equipment Rental		Platinum Health Care, LLC	100.00%	2,008	2,008	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 315,000			$ 191,152	$ * (123,848)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Ben Klein	Owner	Administrative	12.50	See Attached	7	14.58%	Mgmt Fees	$ 103,415	17-03	1
2	Brian Levinson	Owner	Administrative	12.50	See Attached	10	20.83%	Mgmt Fees	103,415	17-03	2
3	Mark Shapiro	Owner	Administrative	12.50	See Attached	11	22.92%	Mgmt Fees	103,415	17-03	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 310,245		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Platinum Healthcare Consultants, LLC
Street Address: 640 E. Pearson
City / State / Zip Code: Des Plaines, IL 60016
Phone Number: (847) 699-7500
Fax Number: (847) 699-8148

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Patient Days	449,397	13	$ 3,053	$	82,992	$ 564	1
2	5	Utilities	Patient Days	449,397	13	5,094		82,992	941	2
3	6	Repairs & Maintenance	Patient Days	449,397	13	4,450		82,992	822	3
4	19	Professional Fees	Patient Days	449,397	13	128,024		82,992	23,643	4
5	20	Fees, Subscriptions	Patient Days	449,397	13	9,928		82,992	1,833	5
6	21	Office Expenses	Patient Days	449,397	13	138,737		82,992	25,621	6
7	21	Clerical Salaries	Patient Days	449,397	13	456,710	456,710	82,992	84,343	7
8	24	Education & Seminars	Patient Days	449,397	13	1,795		82,992	331	8
9	25	Travel	Patient Days	449,397	13	10,496		82,992	1,938	9
10	25	Travel	Direct Cost		1	5,331				10
11	27	Employee Benefits	Patient Days	449,397	13	78,263		82,992	14,453	11
12	26	Insurance	Patient Days	449,397	13	14,694		82,992	2,714	12
13	30	Depreciation	Patient Days	449,397	13	6,154		82,992	1,136	13
14	34	Office Rent	Patient Days	449,397	13	64,933		82,992	11,991	14
15	17	Administrative Salary	Patient Days	449,397	13	101,878	101,878	82,992	18,814	15
16	35	Equipment Rental	Patient Days	449,397	13	10,873		82,992	2,008	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,040,413	$ 558,588		$ 191,152	25

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Universal			Insurance Financing			$ 75,804	$			$ 5,321	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Albany Bank & Trust		X	Line of Credit				315,000			44,463	6
7	Due to Shareholders			Working Capital							3,750	7
8												8
9	TOTAL Facility Related						$ 75,804	$ 315,000			$ 53,534	9
	B. Non-Facility Related*											
10	Interest Income										(2,018)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,018)	14
15	TOTALS (line 9+line14)						$ 75,804	$ 315,000			$ 51,516	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 92,074	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 65,954	2
3. Under or (over) accrual (line 2 minus line 1).		$ (26,120)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 65,954	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 39,834	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001	92,074	11
2002	65,954	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CAPITOL CARE CENTER COUNTY SANGAMON

FACILITY IDPH LICENSE NUMBER 0045666

CONTACT PERSON REGARDING THIS REPORT DARRYL BUEKER

TELEPHONE (417) 865-8701 FAX #: (417) 865-0682

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-28-0-401-018	Long Term Care Property	$ 63,056.40	$ 63,056.40
2.	14-28-0-401-006	Long Term Care Property	$ 2,897.60	$ 2,897.60
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 65,954.00	$ 65,954.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 61,806 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	AWNING			2001	6,950		20	348	348	754	9
10	SIGNS & BANNERS			2001	4,354		10	435	435	906	10
11	A/C			2002	505		5	101	101	137	11
12	A/C			2002	5,263		7	752	752	1,379	12
13	MASONRY RESTORATION			2002	4,098		10	410	410	615	13
14	CEILING WORK			2002	1,500		20	75	75	150	14
15	CEILING WORK			2002	1,835		20	92	92	168	15
16	DOORS			2002	5,665		10	567	567	756	16
17	INSTALL GLASS			2002	735		10	74	74	148	17
18	A/C REPAIR			2002	1,202		10	120	120	195	18
19	ELEVATOR REPAIR			2002	2,320		20	116	116	203	19
20	INSTALL GLASS			2002	550		10	55	55	92	20
21	A/C REPAIR			2002	899		10	90	90	127	21
22	FIRE SPRINKLER REPAIR			2002	1,383		10	138	138	196	22
23	WATER PUMP REPAIR			2002	1,566		10	157	157	183	23
24	WATER HEATER			2002	10,018		12	835	835	1,461	24
25	THERMOSTAT REPAIR			2002	2,287		10	229	229	420	25
26	THERMOSTAT REPAIR			2002	825		10	83	83	104	26
27	REPAIR KITCHEN EQUIP			2002	1,695		10	170	170	340	27
28	INSTALL SIGNS			2002	2,710		10	271	271	542	28
29	INSTALL SIGNS			2002	718		10	72	72	144	29
30	ACCESS CONTROL SYSTEM			2002	3,482		10	348	348	696	30
31	ACCESS CONTROL SYSTEM			2002	2,646		10	265	265	530	31
32	ACCESS CONTROL SYSTEM			2002	588		10	59	59	113	32
33	INSTALL SIGNS			2002	977		10	98	98	179	33
34	SHOWER & GUARD RAILS			2002	535		20	27	27	34	34
35	CALL CORDS			2002	599		20	30	30	50	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	RAIL POST	2002	$ 540	$	20	$ 27	$ 27	$ 38	37
38	CURTAIN FOR MAIN DINING ROOM	2003	849		5	99	99	99	38
39	REPLACEMENT FOR ZONAIRE	2003	5,565		20	70	70	70	39
40	FURNISH & INSTALL NEW CONDENSER	2003	1,521		20	13	13	13	40
41	A/C UNIT	2003	1,100		5	37	37	37	41
42	HOYER LIFT	2003	19,216		10	160	160	160	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69	BOOK DEPRECIATION			15,775			(15,775)		69
70	TOTAL (lines 4 thru 69)		$ 94,696	$ 15,775		$ 6,423	$ (9,352)	$ 11,039	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 112,291	$ 24,042	$ 18,376	$ (5,666)	Various	$ 28,919	71
72	Current Year Purchases	29,178	15,835	1,236	(14,599)	Various	1,236	72
73	Fully Depreciated Assets							73
74	Platinum Healthcare LLC	11,365	7,289	1,136	(6,153)		1,304	74
75	TOTALS	$ 152,834	$ 47,166	$ 20,748	$ (26,418)		$ 31,459	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 247,530	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 62,941	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 27,171	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (35,770)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 42,498	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Walnut Ridge, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 797,051			3
4	Additions	Platinum Allocation			11,991			4
5								5
6								6
7	TOTAL				$ 809,042 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 76,197 Description: Copier $17,381; Beds/mattresses $53,038; Gas Cylinder $3,285; Various $485; Platinum Allocation $2,008
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	See attached list		$	$ 67,015	17
18					18
19					19
20					20
21	TOTAL		$	$ 67,015	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-03	hrs	$		$ 367,675	$		$ 367,675	1
2	Licensed Speech and Language Development Therapist	10a-03	hrs			89,554			89,554	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs			340,188			340,188	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				366,570		366,570	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab	39-02					1,681		1,681	13
14	TOTAL			$		$ 797,417	$ 368,251		$ 1,165,668	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (19,082)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 300,738)	2,624,177		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	140,507		6
7	Other Prepaid Expenses	1,920		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,747,522	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	82,900		15
16	Equipment, at Historical Cost	151,591		16
17	Accumulated Depreciation (book methods)	(126,382)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposit/Escrow	349,528		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 457,637	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,205,159	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,072,402	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	231,148		30
31	Accrued Taxes Payable (excluding real estate taxes)	45,413		31
32	Accrued Real Estate Taxes(Sch.IX-B)	65,954		32
33	Accrued Interest Payable	(1,774)		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	274,243		36
37	Due, Other & Advance Billing	354,876		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,042,262	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	315,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 315,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,357,262	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 776,466	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,133,728	$	48

***(See instructions.)**

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 274,686	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 274,686	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	501,780	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 501,780	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 776,466	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,083,686	1
2	Discounts and Allowances for all Levels	(1,033,709)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,049,977	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,811,686	6
7	Oxygen	18,051	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,829,737	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	500	13
14	Non-Patient Meals	187	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	418,116	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,661	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 420,464	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,018	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,018	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Parking Lot $50; Vending $3,978; Misc (1,666)	2,362	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,362	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,304,558	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,591,695	31
32	Health Care	4,140,823	32
33	General Administration	2,480,719	33
	B. Capital Expense		
34	Ownership	1,083,866	34
	C. Ancillary Expense		
35	Special Cost Centers	368,251	35
36	Provider Participation Fee	137,424	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,802,778	40
41	**Income before Income Taxes (line 30 minus line 40)****	501,780	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 501,780	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,673	1,751	$ 64,263	$ 36.70	1
2	Assistant Director of Nursing	4,258	4,437	139,595	31.46	2
3	Registered Nurses	4,127	4,511	112,296	24.89	3
4	Licensed Practical Nurses	54,783	62,983	1,128,905	17.92	4
5	Nurse Aides & Orderlies	113,918	126,368	1,443,243	11.42	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	829	834	8,790	10.54	8
9	Activity Director	1,867	2,043	24,226	11.86	9
10	Activity Assistants	7,445	7,856	74,451	9.48	10
11	Social Service Workers	3,382	3,543	59,830	16.89	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,127	26,205	12.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	35,199	37,386	286,531	7.66	15
16	Dishwashers					16
17	Maintenance Workers	11,859	11,928	143,373	12.02	17
18	Housekeepers	16,800	20,405	170,278	8.34	18
19	Laundry	19,237	19,726	172,338	8.74	19
20	Administrator	1,845	1,950	82,592	42.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,371	24,059	509,904	21.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	301,577	331,907	$ 4,446,820 *	$ 13.40	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	569	$ 27,238	01-03	35
36	Medical Director	Monthly	25,931	09-03	36
37	Medical Records Consultant	28	2,236	10-03	37
38	Nurse Consultant	Fees	68,892	10-03	38
39	Pharmacist Consultant	Monthly	12,480	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	56	3,164	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	653	$ 139,941		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Suzanne E. Boston	Administrator		$ 78,938
Cynthea Schaaf	Administrator		3,654
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,592

B. Administrative - Other

Description	Amount
Management Fees	$ 325,020
Home Office (Adjusted out on Page 6A)	363,157
TOTAL (agree to Schedule V, line 17, col. 3)	$ 688,177
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Stone, McGuire & Benjamin	Legal	$ 30,321
Sarnoff & Baccash	Legal	6,728
Daniel Maher	Legal	2,183
R. Peelo $3,580; FR&R $2,097	Accounting	5,947
Krupnick Bokor Kagda Brooks	Accounting	1,000
BKD	Accounting	15,000
Personal Planners	Unemployment Consulting	6,369
National Info-Tech Center	Data Processing	299
Ameripay Payroll	Data Processing	11,821
Management Data	Data Processing	17,544
Maxxsource	Data Processing	1,250
Robinson Assoc	Data Processing	19,048
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 117,510

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 114,599
Unemployment Compensation Insurance	100,850
FICA Taxes	326,248
Employee Health Insurance	94,178
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	747
Employee Benefits	9,817
TOTAL (agree to Schedule V, line 22, col.8)	$ 646,439

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	1,407
(Indicate # of checks performed 198)	
Licenses	5,758
Advertising & Promotions	54,555
Dues & Subscriptions	10,585
Allocation from Platinum	1,833
Less: Public Relations Expense	(54,555)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,583

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,884
Allocation from Platinum	331
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,215

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CAPITOL CARE CENTER # 0045666 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CAPITOL CARE CENTER **#** 0045666 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **137,424**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.